State Child Fatality Review Report
SFY 03-04
G.S. 143B-150.20

Family Support and Child Welfare Services Section
Division of Social Services
NC Department of Health and Human Services

2004

Report to the General Assembly
From the State Fatality Review Team

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Executive Summary

The Department of Health and Human Services, Division of Social Services, has the responsibility to convene a State Child Fatality Review Team to "conduct in-depth reviews of the child fatality which occurred involving children and families involved with local Departments of Social Services child protective services in the 12 months preceding the fatality." The purpose of these reviews is to "implement a team approach to identifying factors which may have contributed to conditions leading into the fatality and to develop recommendations for improving coordination between local and State entities which might have avoided the threat of injury or fatality and to identify appropriate remedies." These reviews are mandated by statue (G.S. 143B-150.20) with specified team membership that includes representatives from the Division of Social Services, the county DSS, representatives from the local Community Child Protection Team (CCPT), the local Child Fatality Prevention Team (CFPT), local law enforcement, a medical expert, and a prevention specialist.

The reviews consist of interviews with selected individuals and reviews of case records of the county DSS and other agencies that provided services to the child and family. The process focuses attention on the role and involvement of the broader community in protecting children. A formal report is issued at the conclusion of each review that includes the findings and recommendations from the State Child Fatality Review Team. The team presents these findings and recommendations in a public meeting of the Community Child Protection Team. The written report is available to anyone who requests it. Following the issuance of each report, Division of Social Services staff present the recommendations that have statewide impact to the State Child Fatality Prevention Team in an effort to identify the most appropriate state level entity to follow up on each state level recommendation.

During SFY 03-04, 34 final fatality review reports were issued following completion of the reviews. During the year, the Division of Social Services identified 38 child fatalities that met the criteria for a State Child Fatality Review Team review out of 157 deaths reported. Out of the 38 deaths, neglect was suspected to have contributed to the fatality in 32 cases and abuse was suspected in 6 cases.

Throughout the reviews conducted during the year, review teams identified six major themes most often. First, the review teams identified the need for the Division of Social Services to provide training regarding safe sleeping and safe sleeping equipment, specifically for infants. Secondly, fatality reviews identified the need for Division of Social Services agencies to improve and educate communities on their duty to report suspected child abuse, neglect or dependency. This education should be provided to community partners and stress the process of reporting and outcomes of protecting children in our communities. The third major theme involved the need for Child Protection Services to have immediate accessibility to the Administrative Office of Courts Data System. The fourth major theme identified was the impact of Domestic Violence in the Community. The need for thorough investigations of child fatalities constituted the fifth major theme. Finally, completion of thorough Child Protective Services Investigations/Assessments was significant in child fatality reviews. Additional themes and issues were identified and will be listed in Appendix A to this report. Appendix B lists accomplishments by local communities as a result of recommendations from reviews.

State Child Fatality Review Team
Annual Report

Pursuant to G.S. 143B-150.20, the following is the State Child Fatality Review Team annual report to the N.C. General Assembly for SFY 03-04. This report includes a summary of findings and recommendations of child fatality reviews conducted by the State Child Fatality Review Teams during SFY 03-04. These teams conduct multidisciplinary reviews when there is suspicion that neglect or abuse caused a child's death and the county DSS children's services program was involved with the child or family any time in the previous year.

I. History

In 1997, the General Assembly enacted G.S. 143B-150.20 and established the State Child Fatality Review Team to conduct in-depth reviews of any child fatalities which have occurred involving children and families involved with local departments of social services child protective in the 12 months preceding the fatality.

The collaborative, multi-disciplinary approach to these reviews, along with information available to the public through the review reports, make these reviews learning tools for the entire community. These reviews can teach us how we can improve our efforts to prevent future child deaths.

Feedback from those involved with State Child Fatality Review Teams has been that there is ownership by the local communities with Review Team recommendations and commitment to implementation of the resulting action plans. The State Child Fatality Reviewers have implemented six-month follow-up contacts with the local Community Child Protection Teams (CCPT's) after a review is completed. These follow-up contacts with the CCPT's focus on the progress at the local level in implementing any systemic changes as a result of the recommendations from the Review Team.

II. Review Process

Currently, child fatality reviews are conducted as follows:

A. **By State law, anyone who has cause to suspect that a child has died as the result of maltreatment must report the case to the director of the county Department of Social Services (DSS).**
B. The DSS reports to the Department of Health and Human Services, Division of Social Services (the Division) information that they receive regarding any child who is suspected to have died as a result of maltreatment.
C. The Division determines whether the necessary criteria are met to invoke a review by a State Child Fatality Review Team based on information from the county DSS and any local law enforcement or health care professional who was involved in investigating the child's death or the death scene.

D. A State Fatality Review Team is convened, including representatives of the Division of Social Services, the county DSS, and representatives from the local Community Child Protection Team, the local Child Fatality Prevention Team, local law enforcement, a medical expert, and a prevention specialist.

E. Division staff on the team begins all reviews with an introduction about the review process to all participants.

F. The review consists of interviews with selected individuals and reviews of case records of the county DSS and other agencies that provided services to the child and family. The process focuses attention on the role and involvement of the broader community in protecting children.

G. The team writes a report that includes the findings of the review and recommendations for system improvement.

H. The team presents these findings and recommendations in a public meeting of the Community Child Protection Team. The written report is available to anyone who requests it.

I. As each State Child Fatality Review Report is completed and released, Division staff present recommendations that have statewide impact to the State Child Fatality Prevention Team in an effort to identify the most appropriate state level entity to follow up on each recommendation. For recommendations that need to be addressed by the Division, a work group established in the Family Support and Child Welfare Services Section (FSCWS) examines the issues identified and presents the recommendations to the FSCWS Management Team for any necessary action.

III. Facts regarding State Child Fatality Review Process

The State Child Fatality Review process is an ongoing one, and there is overlap from one fiscal year to the next. Therefore, reviews conducted and reports issued include fatalities that were reported to the Division and decisions to conduct reviews from the previous fiscal year as well as those from the current fiscal year. Some of the cases identified for review in the current fiscal year will be reviewed in the next fiscal year. During SFY 03-04, 34 final fatality review reports were issued following completion of reviews. One review involved the deaths of six siblings.

The State Division of Social Services identified 38 child fatalities (out of 157 deaths reported) in 20 counties that met the criteria for a State Child Fatality Review Team review during SFY 03-04. One of those 38 child fatalities reviews involved six siblings. To meet the criteria for a State Child Fatality Review, there had to be a suspicion that abuse or neglect was a factor in the fatality. In addition, the child or family must have been involved with a county Department of Social Services (DSS) child protective services in the 12 months preceding the fatality. Of these 38 child deaths, neglect was suspected in 32 cases and abuse was suspected in 6 cases.

IV. Lessons Learned

The State Child Fatality Review Teams often identify similar issues in the cases that they review. At other times, there may be a major issue identified that had not been noted previously but that has statewide impact. Other findings are more case specific or community specific.

The six most commonly identified major findings and lessons learned from the 34 child fatality reviews completed during SFY 03-04 are summarized here so that the State Division of Social Services, county Departments of Social Services, and other state and county agencies can make systemic improvements focused on the safety of children. Achievements at the state level related to these findings are noted where relevant at the time the individual fatality reports were issued. Appendix A reflects recommendations that were identified less often or that were more case-specific but that were still important recommendations that should be considered statewide. Appendix B reflects achievements at the local level that have resulted from recommendations from State Child Fatality Reviews.

A. Training on Safe Sleeping Practices

Over the past fiscal year, a substantial number of infants died of a result of suffocation, mechanical wedging, or asphyxiation in relation to sleeping patterns and practices. These deaths occurred due to inappropriate bedding in cribs, children sleeping on couches with parents, or being wedged between a mattress and a wall. Recommendations include the Division of Social Services addressing safe sleeping practices and equipment in trainings for social workers and foster parents, and collaborating with community partners to provide training to service providers that have contact with families in the home setting. Many concerns surfaced around young service providers who may not have personal experience on safe sleeping equipment. Training should be focused on how to assess and recognize safe sleeping patterns and sleeping equipment based on developmental stages of children.

The Division of Social Services already offers a variety of opportunities that safe sleeping and safe sleeping equipment could be incorporated into. Additionally, MAPP (Model Approach to Partnership in Parenting) is required by families in order to become a licensed foster parent. This training could be incorporated into MAPP or as an additional in-service to foster parents.

The Health Department has an established training on safe sleeping. They, inconjuction with the American Pediatric Society, are strong advocates of the Back to Sleep Campaign. Several recommendations from the fatality reviews are that the Division of Social Services should partner with existing agencies and support established campaigns that promote the safety and well being of infants while they sleep. It is felt that this partnership should occur at both the state (during trainings) and county levels continue to stress the importance of safe sleeping of infants.

B. CPS Reporting, Intake Process and Multiple Response System

All citizens are responsible for reporting child abuse. North Carolina G.S. 7B-301 states:

> Any person or institution who has cause to suspect that any juvenile is abused, neglected, or dependent, … or has died as a result of maltreatment, shall report the case of that juvenile to the director of the department of social services in the county where the juvenile resides or is found.

This year the State Child Fatality Review Teams often found that reports of suspected abuse or neglect were not made to the local DSS with tragic consequences, as in previous years. Many reviews revealed law enforcement patrol, first responders responded several times to a home of domestic violence and substance abuse prior to the unfortunate death of a child who lived in the home. In addition, many professionals did not make reports when presented with information that warranted a report of suspected abuse and/or neglect. Recommendations from the fatality review teams included the need for more training in the local communities about the requirements for reporting suspected child abuse and neglect, as well as increased public awareness campaigns on how to report such suspicions. Mental health agencies, domestic violence shelters, all hospital and emergency room staff, pediatricians, county employees, educational personnel, emergency management staff, and law enforcement agencies need to be particularly targeted for training on recognizing signs of abuse and neglect and on the requirement for reporting suspicions to DSS. One recommendation was that there should be statewide training on the aspects of reporting child abuse and neglect for professionals outside of the DSS system and for county staff in other program areas, such as Environmental Health. Another recommendation was that the Department of Health and Human Services should require all state and local agencies under the auspices of the Department incorporate in their orientation and staff training programs the aspects of reporting.

Additional clarification is needed with all first responders to child fatalities (EMS, local law enforcement, hospital emergency room staff, medical examiners) about the need to make a report to DSS when a child dies and there are surviving children in the home.

It should be noted that Children's Services Program Management Standards issued by the Division of Social Services requires that all county Departments of Social Services provide regular community awareness and public education programs on recognizing and reporting abuse, neglect, and dependency. Although all of the counties provide regular ongoing community awareness and public education programs, these efforts continue to be needed.

In addition to local efforts, Prevent Child Abuse North Carolina has long played a vital role in raising public awareness statewide about recognizing abuse and neglect and how to report suspicions to the local DSS. This organization has thirty (30) affiliates statewide and has the goal of identifying a member or an affiliate in each community in the state. Through their Helpline (1-800-CHILDREN), they provide information and guidance to citizens on how to report suspected abuse or neglect to DSS. They also provide a Prevention Resource Center that has public education and awareness material and training curricula that is available to local CCPT's and CFPT's. Their web site is also easily accessible at www.preventchildabusenc.org. The organization is in the process of providing training across the state for local community educators, after-school personnel, and child care employees and anticipates around 1,000 individuals being trained. This training is designed for the trainees to have the capacity to return to their local communities to train others in the community on recognizing abuse and neglect and how to report.

In addition to finding that suspicions of abuse or neglect were not always reported to DSS by the community, the review teams identified related issues that involved the DSS intake process. There were several instances where someone from the community believed that they had enough information to report to DSS. Persons making a CPS report to DSS are often emotional when reporting the information that they have. Information is best received and analyzed by the intake worker if the information is as factual as possible. One recommendation was that intake workers need to ask clarifying questions when using the Structured Intake Tool to assist callers in giving specific, factual information and in defining clearly what they mean. Clear and complete information from the reporter must be documented on the intake form including all allegations of abuse and neglect that need to be addressed by the investigative worker.

Approved by the Children's Services Committee of the North Carolina Association of County Directors of Social Services, the Division of Social Services implemented the Strengths-based, Structured Intake process and tools that became effective June 1, 2003 for all 100 counties. This process provides social work staff with a structured intake instrument that guides discussions with reporters and utilizes decision trees to assist with more consistent intake decisions from worker to worker and county to county. The Strengths-based, Structured Intake process is one of the seven MRS strategies.

The Multiple Response System (MRS) will be able to address the many recommendations from the child fatality reviews that called for better information sharing and collaboration across agencies in serving children and families. Also this approach provides the Division of Social Services the opportunity to build on the efforts of using family-centered principles of partnership woven throughout MRS seven strategies to achieve our mission of ensuring safe, nurturing and permanent families for children. The Division of Social Services piloted the Multiple Response System in ten counties across the state in August 1, 2002. The North Carolina General Assembly authorized the expansion of the MRS demonstration

project to county departments of social services. As of January 14, 2004, 42 additional county departments of social services were included in the expansion for a total of 52 counties practicing this approach. In one component of this MRS pilot, agencies are using Child and Family Teams in CPS in-home services cases. Like the Family Team Decision-Making meetings in Family to Family, these Child and Family Teams bring the family together with their natural supports and community resources for planning and decision-making. The other five strategies of MRS are:

1. A choice of two approaches to reports of child abuse, neglect or dependency
2. Coordination between law enforcement agencies and child protective for the investigative assessment approach
3. A redesign of in-home services
4. Implementation of Shared Parenting meetings in placement cases
5. Collaboration between Work First and child welfare programs

C. CPS accessibility to the Administrative Office of the Courts Data System

County Departments of Social Services/Child Protective Services not having immediate access of the state wide criminal information system was identified in all child fatality reviews as having severe consequences that ended in child fatalities. The child fatality reviews specifically cited that immediate safety for children and CPS worker safety was compromised because of not having immediate access to the Administrative Office of the Courts Data System (AOC) to conduct criminal background checks, especially investigations and child placements. Having accessibility to AOC will enable CPS staff to have better information to make better assessments to provide services to families.

The Division of Social Services, as of December 2003, is currently piloting AOC access in collaboration with AOC in 10 counties. By the end of the 2003-2004 fiscal year, the Division of Social Services will have extended the access to all 100 county Departments of Social Services. The ability to access records via AOC 24 hours/7 days a week will allow CPS to conduct criminal background checks within their counties and statewide.

D. Domestic Violence in the Community

Violence committed by family members upon other family members has plagued North Carolina for many years. There has been a reluctance to acknowledge the extent of this violence as well as the tremendous societal costs it bears, which has frustrated efforts to reduce it. This reluctance is seen through the communities failure to report domestic violence to DSS, lack of education/training to patrol officers in handling violations of 50-B orders, a protocol that requires victims to report to the magistrates office with each violation of a 50-B, and allowing protective orders to be dropped/dismissed prior to the expiration of a year. In the face of this reluctance, two strong but separate movements, the movement to prevent child abuse and the battered women's movement have emerged.

In 2002, Chief Justice I. Beverly Lake and Carmen Hooker Odom, Secretary of Health and Human Services enthusiastically agreed to chair a task force and appointed 40 members. The task force mission was to design a strategy for North Carolina to adopt policies and practice recommendations and an implementation plan that maximizes the safety of all family members, empowers victims, and holds perpetrators of domestic violence and child maltreatment accountable. One of the task force sub-workgroups consisting of the Division of Social Services, county Department of Social Services, and Domestic Violence experts convened to take the recommendations from the task force and integrate those recommendations into policy and practice as it relates to child protective services. The workgroup also examined long standing issues confronting CPS workers and Domestic Violence professionals. The Division of Social Services policy on Domestic Violence was finalized in January 2004 and updated in September 2004. Training and implementation will occur in the fiscal year 04-05.

E. Investigations of Child Fatalities

It is imperative that all child fatalities involving an unexpected death are thoroughly investigated by law enforcement and that DSS is notified of the fatality to ensure that the surviving children's safety is assessed. Securing a crime scene by law enforcement and completing thorough interviews of those parties and witnesses involved in the investigation can secure vital information that may become contaminated without these actions. Child fatality investigations should be conducted jointly with DSS, the medical examiner's office, and law enforcement as each agency provides a vital role in the process. Notifying law enforcement immediately allows for the medical examiner to have crime scene information that might otherwise be unavailable. DSS can provide important information regarding possible history of the family to ensure ongoing safety of surviving siblings.

North Carolina Department of Health and Human Services, Division of Public Health, Office of the Chief Medical Examiners office and the North Carolina Child Fatality Prevention Team is currently in the process of developing the North Carolina Child Death Investigation Protocol to guide agencies with the collaboration necessary to complete a thorough child death investigation. This protocol stresses the importance of emergency medical services, hospitals, law enforcement, DSS, and the medial examiner establishing a partnership of working together and sharing information. This protocol was not complete at the end of the fiscal year 03-04.

F. Completion of thorough Child Protective Services Investigations/Assessments.

In many of the fatalities reviewed, the review teams identified the need for thorough child protective services investigations and assessments. In a number of the reviews, the allegations were not thoroughly assessed nor was sufficient contact with the family, children or persons who had knowledge about the family maintained to assess the level of risk in families. These steps are an integral part of a thorough assessment and can lead to

tragic outcomes if not completed. A thorough assessment begins at the intake process and does not end until the risk to the children is sufficiently reduced and the case is closed to DSS.

The Children's Service Manual, Chapter 8, Section 1407 "Structured Intake" and Section 1408 "Receiving and assessing reports of abuse, neglect or dependency" guides decision making and practice regarding assessing child protective services intake reports and a thorough assessment of all factors present within a family.

Several reviews identified the need to research internal agency history to assist with identifying patterns during the intake process. Access to AOC records has been beneficial in assessing criminal activities and how they may impact on the safety and well being of children. This access needs to be expanded to all 100 counties to aid in the assessment of risk to children.

Collaboration within DSS, cross county and across state lines continues to be a barrier. Several reviews indicated that communication between internal departments of DSS should enhance services to families. This communication includes child and family team meetings to collaborate and communicate with family members and service providers, discussions with licensing workers prior to placement of children in foster homes and then ongoing monthly communication to address additional needs, and joint home visits when cases have been transferred across county lines. DSS continues to struggle with ensuring children are safe and services are provided when families move across state lines.

V. Conclusion

The contributions of informed state and community professionals that served on the State Child Fatality Review Teams during SFY 03-04 have made this report possible. These individuals devoted countless hours during the reviews, frequently volunteering their time without compensation. The review team members intensively reviewed the circumstances of each child's death and confirmed that protecting children is a shared community responsibility.

The findings and recommendations of these multidisciplinary teams have statewide implications. It is recommended that state agencies and all local communities in North Carolina use this report to examine the issues relevant to the protection of children and the prevention systems in place in order to make any improvements that are indicated. If the lessons learned as a result of a child's death can be applied in such a way as to prevent future fatalities, the state's protection of children will be significantly enhanced and the legislative intent will be met.

Appendix A

Appendix A reflects additional recommendations that were either identified less frequently than those in the body of the report or that were case specific. These are important recommendations that can be implemented statewide.

Cross County Issues

- The Cross County Policy was effective December 2003 and should be followed by all county DSS. In addition, management should consider joint home visits when cases are transferred and counties are in close proximity.

Issues for Judges, Attorneys, and Law Enforcement

- Judges and attorneys involved in a Chapter 50B protective order should state clearly that a court ordered protection cannot be violated when it is consensual or when children are involved.
- Services and visitation should be specifically ordered by judges and spelled out under the "decretal" section of the court order and section of conclusions of law, not just referenced in finding of facts and exhibits.
- Non-DSS custody cases that are before the court system are not monitored. Consideration should be given to legislative expansion of the GAL program or independent GAL's to monitor cases that are non-DSS custody cases.
- Many District Attorneys' Offices have no investigators that could coordinate a comprehensive effort to ensure all information around a child's death is completely explored. There should be advocation by State Representatives for more District Attorney Investigators to the General Assembly.
- The juvenile court system does not always process excessive tardies and absenteeism when involved with juveniles under the courts jurisdiction.
- Judges and District Attorneys should not be dropping or dismissing charges against a parent when they have not completed all that was ordered in court.
- As part of a child fatality investigation, first responders should document body temperature as part of their report.

Medical Examiner Issues

- North Carolina needs a Medical Examiner system that disseminates, distributes and applies the science and other information that exits in the central State Medical Examiner's office through every community and county requiring that information.
- Pathologists should always clearly specify the cause of death or that it cannot be determined in the final autopsy report.
- A protocol should be developed by the State Medical Examiner's office and regional child abuse experts to rule out possible child abuse prior to ruling SIDS.
- Local Medical Examiners should meet personally with the law enforcement officer investigating a child fatality.
- Local Medical Examiners also should have contact with DSS to establish if there is history or knowledge relevant to the situation.

- Local Medical Examiner's should obtain pertinent information regarding the crime scene if they are not at the crime scene and should pass on this information to the pathologist.
- Pathologists and law enforcement should have direct contact and law enforcement should attend autopsies whenever possible.

Parenting Education/Community Awareness

- Community awareness of the dangerous and potential tragedies should be provided regarding infants testing positive for illegal substances at birth.
- Every year, children die due to gun related incidents, therefore continued public awareness regarding gun safety and safe storage of fire arms should be provided.
- Collaboration should occur between DSS and the Health Departments to provide SIDS awareness trainings to DSS staff and the community and to support the Back to Sleep Campaign.
- Community awareness campaigns on the dangers of insecticide poisoning, safe storage of chemicals and poison prevention strategies should continue to be provided by doctors and other home based community providers.

Mental Health

- All 100 counties do not have access or required funding to complete parent capacity assessments.

Resistant Families in Child Protective Services

- Parent- initiated placements should be used when it is a short term solution, the parent will participate and follow through with the case plan and it is not a substitute for bringing a child into custody because of safety issues especially when parents would not participate in the development or follow through with the case plan.
- The North Carolina Division of Social Services should review the utilization of safety plans as related to the legal authority to enforce them and provide guidance for county DSS agencies when the plan is not followed. Safety plans should be specific and monitored for compliance. When violation of the safety plan increases risk to the children, supervisors and workers should consult with attorneys regarding petitioning for custody.
- When a case has been opened for a Child Protective Investigative Assessment and a Safety Resource (alternative living arrangement) is still necessary because inappropriate behavior has not changed and safety issues remain if the child were to be returned to the parent, the agency should not substantiate and then close the Child Protective Investigative Assessment until that Safety Resource (alternative living arrangement) is legally secure. The local DSS should petition the court for substantiated Child Protective Services cases and request a court ordered placement when safety issues warrant a Safety Resource (alternative living arrangement).
- When agencies make a referral for a family, they should follow up with the service provider to see if the family made an appointment or kept an appointment that was made when a child's wellbeing is at stake. The agency should be clear about what the response will be when an agreed upon plan of action is not carried out by the family.
- Children cannot be protected when legal barriers prevent service providers from gaining immediate access to children. Statutes must allow for immediate and objective access to children in an appropriate environment for assessment. It is imperative for children's safety

to distinguish a person's property, which might be protected by constitutional right, from the lives of children who may need protection within the legal system. It should be remembered when considering laws pertaining to protection of children that parental rights can be in conflict with children's safety.

- The Division of Social Services should provide guidance to agencies in the form of specific policy, protocols and training for social workers when encountering resistant families, as this resistance in and of itself greatly elevates the risk to children.
- Kinship care assessment does not adequately reflect other children residing in the home. NCDSS should consider revising this form to account for such children.

School Issues

- Public schools should be more proactive when it comes to attendance. In addition to attendance being important for school achievement, it is also an indicator relating to the child's health and wellbeing. The local CCPT's should hold discussions with their school systems regarding more aggressive enforcement of existing policies including any legal recourse and to better educate the community about the truancy hotline and school options for ensuring school attendance.
- The State Child Fatality Task Force should look at the correlation of home schooling and protection issues for children.
- The NC Office of Public Instruction should develop a centralized computer system to track school attendance and to issue an alert if children are withdrawn and not re-enrolled or record request submitted in a reasonable amount of time.
- Schools should utilize community resources when concerns do not rise to the level of abuse, neglect or dependency. School social workers should be well versed on these community resources to provide assistance to teachers in making appropriate referrals.
- Schools usually experience misbehavior/behavior disorders on an early basis and need to ensure that these behaviors are appropriately assessed to identify and evaluate potential treatment.
- The State Board of Education should support a "bullying policy" that assists with identification and intervention of these types of behaviors.
- Schools should follow procedures set forth in N.C.G.S. 115C-378 regarding the accumulation of 10 unexcused absences in a school year.
- The Division of Social Services should incorporate into policy that when photograph(s) are taken that they be identified by name, time and date. It is also to be documented in the case record that photographs were taken and by whom.

Division of Social Services and County Department of Social Services Supervisory Oversight

- County DSS should encourage all agencies to call and discuss with them any case of suspected neglect. County DSS also will suggest to agency callers that the CCPT is a resource if the concern exists and it does not meet the criteria for neglect or abuse.
- On going training should be provided to social workers regarding chronic illness and medically fragile children as it relates to neglect and abuse by the Division of Social Services.
- Consistent and thorough supervision should ensure all potential victim children are identified and assessed by County DSS management.

- County DSS should utilize after-hours workers to monitor supervision of families. County DSS management should remind workers and supervisors of the importance of utilizing after hours workers.
- The local CCPT's should become more of an active resource for the interagency staffing of particularly problematic cases involved with the County Department of Social Services.
- Supervisors of County DSS blended teams should ensure that all cases are staffed a minimum of once a month. County DSS supervision should include continually evaluating whether new information should be taken as a new report for investigation. County DSS should review its agency's mission, goals and the role of supervisors in meeting these goals.
- The local DSS should ensure that a multi-level ongoing accountability and quality improvement plan is in place to assure that CPS protocols are carried out.
- County DSS supervisors should look at the quality of collateral contacts to ensure that they get the best information possible in order to ensure the protection of children.
- Team meetings should occur anytime that several agencies are involved in the same family. When County DSS is involved they should initiate meetings with various agency personnel and establish roles and responsibilities for all the workers involved with the family. This community team should see that the intervention is tailored to the client to include cultural issues. County DSS supervisors should ensure team meetings are scheduled as appropriate. Supervisors should consider attending team meetings with inexperienced workers.
- Close attention should be paid to determining who might be able to provide objective information in which to verify parental reports.
- Legal interventions by County DSS should be evaluated when non-compliance of case plans occurs and risk factors remain present.
- It is imperative that DHHS-DSS develop a state wide tracking system for families involved in the child welfare system.

<u>Medical Issues</u>

- When a county DSS has a medical advisor on staff, staff should ensure that the medical advisor is informed of injuries to children in DSS custody and proper medical attention should be sought to examine such injuries.
- Families from rural counties may have difficulty in accessing medical care due to lack of private and public transportation and lack of medical providers.
- The intensive home visitation program through the Health Department has a cut off referral date of two weeks following the birth of a child in reference to a medical diagnosis. This cut off policy should be reviewed to look at any medically fragile child that is diagnosed within the first year of life as appropriate referrals for this program.
- The Child Service Coordination program is not fully utilized. Additional attention should be focused on ensuring nights and weekend hospital staff understands the referral process and the importance of these referrals.

Appendix B

Appendix B reflects some of the achievements reported by local communities that resulted from recommendations from State Child Fatality Reviews.

- The State Board of Education approved a bullying policy for all school districts on July 1, 2004. This policy requires a representative from each system to be trained in anti-harassment issues. This discussion began in October 2003.
- Train-the-Trainer sessions were provided across the state in reference to the Infant Abandonment Law and counties were encouraged to develop protocols on how to handle infants that are safely surrendered.
- DHHS, Division of Social Services implemented a Cross County Policy that went into effect in December 2003.
- Harnett County worked with Harnett County public schools to distribute brochures regarding water safety at the end of the 03/04 school year. These brochures were also available in Spanish. In addition, they have worked with local radio stations to discuss summertime safety. The Safe and Sound Children's Health Fair in April 2003 also addressed water safety.
- The Durham chapter of Parents of Murdered Children and the Duke Community Bereavement Center sponsored a workshop called "The Worst Has Happened, Now What?" at the Durham County library for families and friends of homicide victims.
- Prevent Child Abuse of North Carolina sponsored their 1st annual golf tournament "Fore the Children" in Wake County and was very successful.
- Wake County DSS joined with Raleigh Police Department to develop a joint Child Development/Community Policing Project and collaborated with Cary Police Department on issues of Domestic Violence.
- Wake County DSS added a full time Spanish Interpreter to their Child Welfare staff as well as created a Spanish Report Line.
- Buncombe County Child Fatality Prevention and Review Team participated in the Children First Children's Fair by sponsoring and staffing a Water Safety Booth.
- New Hanover County DSS worked jointly with the FBI to provide methamphetamine training to all child service agencies.
- New Hanover County CCPT and the Health Department issued public service messages regarding the Back to Sleep Campaign.
- Onslow County DSS sponsored a training workshop for DSS staff, community members and foster parents on Reactive Attachment Disorder. They also sponsored a workshop on Shared Parenting.
- Onslow County DSS continue to provide education to the community, churches, school systems and civic organizations on the dynamics of child abuse, neglect and dependency and how the community needs to partner together to protect children.
- Onslow County DSS adoption unit held an Adoptions Awareness Day to promote the need for more foster and adoptive families. The adoptions unit also sponsored a float in the Jacksonville Christmas Parade.
- Onslow County DSS received the BASES award from the school system for their ongoing support and collaboration with the school system. DSS presented a plan at the State of the Child Breakfast which kicked off Child Abuse Awareness month in April regarding the development of a countywide strategic plan to deal with child issues to include child abuse and neglect.